

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN2ADA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/03/2010
NAME OF PROVIDER OR SUPPLIER COMMUNITY COUNSELING CENTER DETOX SERVICE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 EAST LONG STREET CARSON CITY, NV 89701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	<p>Initial Comment</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>This Statement of Deficiencies was generated as a result of the Complaint Investigation conducted at your facility on 3/3/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for thirty-two residential program beds for the treatment of abuse of alcohol and drugs. One employee files were reviewed.</p> <p>Complaint #NV00024551 was substantiated, but due to the actions taken by the facility, no deficiencies were cited.</p>	D 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE